

The Chinese experience of hospital price regulation

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This paper analyzes the distortion effects of the hospital pricing policies in China. To help maintain equitable access to hospital services, the Chinese government regulates prices of hospital services, and provides subsidies to public hospitals. Comparing the regulated fees of selected hospital services with their average unit costs indicates that the average cost-recovery rate of the fees is only 50%. The fees for 90% of the services are less than their average unit costs, while the fees for the high-tech services exceed their costs. Moreover, the State Price Commission allowed a drug profit margin of 15–20% over the wholesale price. The distorted fee schedule affects the behaviour of hospitals. Empirical evidence revealed problems of violation of price regulations (charging a fee exceeding the regulated fee), over-provision of profitable high-tech services and over-prescription of drugs. The Chinese experience shows that low regulated fees cannot reduce the economic burden on patients, and that distorted medical fees can result in distorted service provision and low efficiency of medical resources. Strategies to correct for the price distortions are discussed.

Introduction

To provide health services to its population of 1.2 billion, China has 200 000 health establishments including 62 000 public hospitals (Ministry of Health 1996). China has some 3 million hospital beds in operation, averaging 2.4 beds per thousand people. This is a higher per capita ratio than is found in other low-income regions of the world. Three-quarters of China's total health spending goes to pay for inpatient or outpatient hospital care, and over half of hospital spending is on pharmaceuticals (Wei Ying 1996). Most hospital facilities are owned and operated by the central, provincial, county and city governments. There are about 400 county hospitals (300 beds on average) in China, which make up the third tier of the rural health care system. These hospitals are usually the last point of referral for inpatient treatment of rural residents, since few farmers can afford to be treated at specialized big-city hospitals.

Despite its remarkable achievements in the past, China's health sector today faces two main problems. First, there is widespread inefficiency and inequity in resource use. Second, the growth of health spending has escalated in recent years and, unless cost-containment measures are designed now, financing and delivery arrangements will contribute to rapid cost increase in the future. Total health expenditure per capita grew by 8% per year in real terms from 1978 to 1986, accelerating to 11% per year from 1986 to 1993. Over the same time period GDP per capita grew by 7% per year in real terms. The share of health spending provided by the government budget, exclusive of subsidized care for government workers through Government Employee Insurance (GIS), declined from 36 to 16% of national health expenditures between 1986 and 1993. By contrast, out-of-pocket payments rose from 20% of revenue in 1978 to 26% in 1986 and to 42%

in 1993, transforming the financing base of the health sector. This trend indicates an increasing burden on consumers and thus implies a failure of government pricing policies, which are intended to protect the consumers from excessive medical charges.

Prices for health services in China are set under guidelines established by the State Price Commission. At the heart of the issue of pricing policy is the Yellow Book price list – a detailed listing of thousands of medical procedures, services, and diagnostic tests. The prices are supposedly set high enough to protect and develop the services provided, yet low enough to assure affordability to the users. During the Cultural Revolution, the government tried to increase access by reducing the prices of visits and hospital days to levels that a poor farmer could afford. That tradition continues as prices for most medical services remain below costs, especially for services with large labour input. Despite double-digit inflation in recent years, these listed prices are not often updated in many provinces, thus fixing most health service prices at low levels.

The difficulties caused by these pricing policies can be seen clearly in the hospital setting. Most Chinese hospitals charge patients for each item of service rendered and drugs given; about 85% of revenues come from these charges. In case of running deficits, hospitals received subsidies from the government. A drastic change in hospital financing took place in the early 1980s. As a consequence of the economic system reforms in China and in recognition of the low efficiency of public hospitals, the flexible budget to hospitals was replaced by a fixed budget system. Beginning in 1980, the government allowed a fixed budget to each hospital according to the government's financial ability, and hospital executives were given the autonomy to manage their hospitals, except for the

permanent employment of hospital staff which was still under the control of the government. The hospitals are responsible for their own profits and losses. While the prices of most services were kept low by the Price Commission, the prices of high technology diagnostic tests have been set far above costs to offset losses on other services. Moreover, all hospitals own and operate pharmacies, and drug prices at the retail level are controlled by the State Pharmaceutical Agency. The price structure allows mark-ups of 15% at both the wholesale and the retail level. Hospitals also have an incentive to manufacture their own products to maximize the permitted margin.

The financial pressure on hospitals has been increasing since the hospital budget reform because the increase in the government budget failed to keep up with the increase in input prices and the level of fees had been frozen at the pre-1985 level. National statistics showed that while the input prices of hospital services increased at an annual rate of 18% from 1980 to 1993, the government budget increased at a rate of only 11% (Chang 1996). In real terms, the budget for hospitals was actually reduced. The budget reduction placed hospitals at serious financial risk. About one-third of the public hospitals had to operate in deficit in the first few years of the hospital budget reform (Shi 1987). As a solution to this problem, the regulated hospital fees were increased in the mid-1980s. Since then, the fees have been negotiated by the provincial health authorities (owners of the public hospitals) and the Price Commission every 2–3 years. The goal of cost-recovery reform is to finance hospitals' recurrent costs through user fees, so that government budgets are used only for capital development.

There has been serious debate between health and pricing authorities. According to the health authorities, the increase in regulated medical fees has failed to keep up with the increase in input prices and there is a large gap between the costs and regulated prices. In contrast, the Price Commission officials insist that the increase in medical fees will create an extra economic burden for the people and that a further increase in fees is inappropriate because most of the public hospitals have been financially sustainable since the early 1990s. To help inform the debate and the policy-making process, the Chinese Ministry of Health commissioned the present authors to conduct a study in 1994 to accurately measure unit costs of the major medical service items (Liu et al. 1996). This study involved 17 county level public hospitals and 130 selected service items out of 2500. Drawing heavily on the study, this paper first compares the prices with estimated costs, and compares prices with the actual charges. Then we provide an economic analysis of the distortion effects of hospital pricing structure. Finally we discuss major lessons than can be drawn from the Chinese experiences.

Prices and costs of hospital services

One of the earliest studies on hospital cost estimation indicated that in 1989 the average costs for fairly routine hospital procedures in Shanghai were two to four times the allowed fees for patients paying out-of-pocket, and two to three times the allowed fees for insured patients (Chen 1994). In 1994 we began a study to estimate unit costs of major hospital services,

using modern cost-accounting methods. We found that the regulated hospital fees in Shandong Province allowed an average cost-recovery rate of 50%. Ninety percent of the service items examined had a unit cost of more than the regulated fee (Liu et al. 1996). Table 1 provides a list of the average costs of selected service items for 17 county hospitals in Shandong and their corresponding regulated medical fees. The average cost here included both direct and indirect (overhead) costs of the cost centres, and both recurrent and capital costs. The indirect cost was allocated using the step-down method. The capital cost was estimated using a national deflator for different types of fixed assets. There are two reasons for including capital costs in our estimation of unit costs of hospital services. First, unlike some other countries (e.g. the US), where charges for physician services and hospital services are billed separately, China lumps everything (including capital and labour costs) together in one hospital bill. Second, the State Pricing Commission takes into account the recovery of capital costs when setting prices for an increasing number of services, especially for services involving the use of high technology equipment. The percentage of capital costs varies among services, ranging from 4.7% of costs for appendectomy to 91.2% for quick freezing microtome (Liu et al. 1996). The medical fees regulated by the government were found to be much lower than the estimated costs of these service items. The fee levels of all the 32 selected service items were lower than their costs. Among these service items, only seven services had a cost-recovery rate of more than 50%.

We estimated costs of 130 service items. Based on the expert opinions of a physicians panel, 130 services were selected, because they represented those services most frequently provided by different levels of hospitals. A comparison of estimated costs of those services with their regulated fees (Liu and Meng 1996) indicated that about 6% of the services had a cost-recovery rate of less than 10%; 12% had a recovery rate between 10 and 20%; about half had a recovery rate between 21 and 50%. In terms of service types, the recovery rate for hospital registration procedure was only 16%; the rate for hospital bed and board was only 25%; the recovery rate for surgical operations was about 30%; for general examinations and treatments, it was 40%. In only 4% of services (especially high-tech services) were fees set higher than their costs. For example, the cost for CT scanning was 110 yuan, while the regulated fee was 180 yuan; the cost for remote control x-ray examination was 35 yuan, but the fee was regulated at 50 yuan.

The above analysis clearly indicates the difficulties in the hospital setting caused by the pricing policies, because of the large gap between the average unit cost and regulated fees. Before the hospital budget reform, this gap was fully covered by the government budget. After the reform, during the early years of the 1990s, the government budget could cover only about 20% of this gap (Henan Department of Health 1993; Li 1993; Zhou 1993), namely 10% of the hospital cost. This means that 40% of the hospital cost and 80% of the gap between the unit costs and the regulated fees needs to be met by other sources of financing. If hospitals rely on revenues and the pricing policies are to be strictly adhered to, hospitals have to run constant deficits. There are only two possible

Table 1. The comparison of average costs of hospital service items with their regulated medical fees in Shandong, China

Service items	Cost (yuan)	Fee (yuan)	Cost–Fee (yuan)	F/C
Registration	3.18	0.50	2.68	0.16
Hospital day	16.04	4.00	12.04	0.25
Appendectomy	145.38	70.00	75.38	0.48
Subtotal gastrectomy	239.93	110.00	129.93	0.46
Hepatectomy	293.07	120.00	173.07	0.41
Closed mitral commissurotomy	321.07	140.00	181.07	0.44
Excision of brain tumor	385.39	120.00	265.39	0.31
Replacement of hip prostheses	361.83	130.00	231.83	0.36
Prostatectomy	217.28	90.00	127.28	0.41
Open reduction of hip joint	219.77	120.00	99.77	0.55
Caesarean section	170.83	90.00	80.83	0.53
Hysteromyectomy	209.60	70.00	139.60	0.33
Cataract extraction	139.25	90.00	49.25	0.65
Unilateral cleftlip	127.06	50.00	77.06	0.39
Posthetomy	63.49	15.00	48.49	0.24
Excision of mastofibroma	99.02	40.00	59.02	0.40
Blood routine	5.49	1.00	4.49	0.18
Urine routine	2.53	0.60	1.93	0.24
Hepatic function	12.32	5.00	7.32	0.41
Blood sugar	7.65	1.50	6.15	0.20
Iliac puncture	10.36	3.00	7.36	0.29
General sealing	1.27	0.80	0.47	0.63
Artificial abortion	9.53	8.00	1.53	0.84
Dental extraction	4.57	5.80	2.77	0.39
Intramuscular injection	0.80	0.25	0.55	0.31
General fluoroscopy	1.78	1.00	0.78	0.56
X-ray film (8 _ 10 inch)	11.21	3.80	7.41	0.34
Normal delivery	49.74	15.00	34.74	0.30
Pasological sample	11.73	15.00	-3.24	1.28
Ultrashort wave therapy	3.81	1.50	2.31	0.39
Electroencephalogram	21.29	10.00	11.29	0.47
B-ultrasonic examination	7.81	5.00	2.81	0.64

Source: Liu (1996).

options for the hospitals to make up the loss resulting from providing the under-priced services: oversell profitable services or flout the system, namely do not follow the rules. Although there have been many anecdotal stories about the ‘under-the-table payment’, we limit the next section to examining the extent to which the pricing policies are followed by the Chinese hospitals.

Prices and actual charges

One of the major institutional challenges faced by transitional economies such as China is law enforcement. People may think that the government budget reduction and the distorted regulated fees would have forced many hospitals in China to close down. In fact, this has not happened. Why? Driven by the financial pressure, hospitals have found many ways to survive including over-charging for services, either by grossly violating the price regulation or by taking advantage of loopholes in the system.

An investigation by the present authors showed that hospitals failed to follow the regulation on hospital fees (Chen and Liu 1994). Table 2 shows the comparison of the average costs of selected service items with the actual charges of randomly

selected county hospitals. It can be seen that, although the prices were set below the cost levels, the actual charges for many services exceeded the regulated fees. According to this study, for 85% of the surgical operation services, the charges exceeded their costs, and the cost-recovery rate was 124%; the charge for birth delivery exceeded the cost by 36%; for 40% of the general examination and treatment services, the charges exceeded their costs. In other words, the hospitals overcharge by a margin of 86 to 90% of the regulated fees. It was estimated that the service revenue generated from over-charging alone can recover 10% of the hospital costs and made up 20% of the cost-fee gap (Liu et al. 1996).

Over-charging was generally achieved by ‘unbundling’ (i.e. splitting one service item into several sub-items in billing practices), and charging patients or purchasers more than the regulated fee. For example, the regulated fee for appendectomy was 70 yuan, which included anaesthesia, disinfecting, surgery, materials and routine drugs. In practice, anaesthesia, disinfecting, materials and drugs were excluded; the 70 yuan charge was only for labour costs; additional charges were issued for other sub-items. As a result, the actual charge was much higher than the regulated price and exceeded the unit costs. The price regulation bureaux frequently conduct audits of

Table 2. The comparison of regulated fees with actual charges by hospitals in Shandong, China

Fee	Cost (yuan)	Charges (yuan)	Ch-Co (yuan)	Ch/Co
Appendectomy	192.28	225.00	32.72	1.17
Subtotal gastrectomy	300.52	365.00	64.48	1.21
Hepatobectomy	346.36	440.00	93.64	1.27
Closed mitral commissurotomy	407.21	515.00	107.79	1.26
Excision of brain tumor	464.62	490.00	25.38	1.05
Replacement of hip prostheses	424.85	1210.00	785.15	2.85
Prostatectomy	254.12	330.00	75.88	1.30
Open reduction of hip joint	337.67	490.00	152.33	1.45
Caesarean section	234.55	285.00	50.45	1.22
Hysteromyoectomy	255.19	310.00	54.81	1.21
Cataract extraction	180.23	190.00	9.77	1.05
Unilateral cleftlip	139.03	130.00	-9.03	0.94
Posthetomy	49.10	40.00	-9.10	0.81
Excision of mastofibroma	55.92	45.00	-10.92	0.80
Blood routine	4.74	4.75	0.01	1.00
Urine routine	2.91	3.50	0.59	1.20
Hepatic function	13.59	5.80	-7.79	0.43
Blood sugar	7.58	4.55	-3.03	0.60
Iliac puncture	11.99	20.00	8.01	1.67
General sealing	1.14	10.00	8.86	8.77
Artificial abortion	11.76	12.00	0.24	1.02
Dental extraction	7.54	6.00	-1.54	0.80
Intramuscular injection	0.95	0.45	-0.5	0.47
General fluoroscopy	2.17	3.00	0.83	1.38
X-ray film (8 × 10 inch)	20.82	14.00	-6.82	0.67
Normal delivery	65.58	105.00	39.42	1.60
Pasological sample	15.36	12.50	-2.86	0.81
Ultrashort wave therapy	4.50	2.50	-2.00	0.56
Electroencephalogram	31.13	16.00	-15.13	0.51
B-ultrasonic examination	9.32	12.50	3.18	1.34

Source: compiled by the authors.

hospitals, and cases of violation can be found in many public hospitals, but so far no effective actions have been taken except for a small, negotiated fine after the annual audit. Even though the phenomenon of over-charging is well known to the health authorities, they do not have a strong incentive to modify hospital behaviour. As owners of public hospitals, health authorities often act as a representative and agent of the hospital industry. Furthermore, in light of the prevalent over-charging behaviour among hospitals, vigorously conducting self-policing on the part of health authorities would amount to offending many of their political constituents.

Pricing structure and incentives

Besides the law enforcement problems discussed above, the current pricing structure in China's hospital sector clearly provides incentives for under-providing or over-providing certain services, depending on profitability. As described in the introduction section, not all of the service items are under-priced. The system thus has two pricing extremes: most services are priced too low, compared to the actual costs; at the same time, high profit margins on diagnostic tests and drugs encourage over-provision in those areas. In this section we analyze the underlying incentive structure of the pricing system and how the incentives are translated into collective behaviour from an institutional point of view.

High-tech medicine

As part of the drive to modernize medicine in China, the price of newly introduced diagnostic tests such as remote control X-ray, CT and MRI, has been allowed to be set at a level high enough to encourage their rapid adoption. A comparison of the cost of a CT scan with allowed fees in Shanghai and Tianjin shows the large profit from this test (Table 3). Faced with this irrational price structure, hospital managers use profitable products to cross-subsidize under-priced products. These organizations now routinely organize investor groups to buy such equipment. They borrow from banks and sell investment shares to staff members to purchase such equipment. Hospitals may also lease equipment from international suppliers with the lease payment set at a percentage of gross revenues generated from the use of the equipment. China is in the midst of a diagnostic equipment race involving most of its hospitals and many health centres. The following examples are illustrative of the problems: Yianjin, a city of 6 million people, had 68 CT scanners in 1993; Anshan, a city of 1.4 million, had 12 CT scanners in 1994; and Qingzhou, a city of 150 000, had four CT scanners in 1997. These numbers all exceed the national equipment distribution standard of one CT scanner per 300 thousand population (Li 1997). A study showed that among the cases tested by CT in 1995, only 10–20% were positive (Mu 1996), a remarkable reduction in

Table 3. Comparison of costs and allowed fees for body CT scan, 1988 (in 1993 yuan)

City	Cost			Allowed fees	
	Fixed	Variable	Total	Self-pay patients	Insured patients
Shanghai	109	47	156	181	362
Tianjin	80	32	113	181	362

Source: Chen Jie (1994).

the case-positive rate from 50% in 1988 (Liu and Chen 1989). This reduction of the case-positive rate may indicate an increasing likelihood of over-utilization of these services. It is estimated that about 10% of the financial gap or 5% of the hospital cost is made up by the profit generated from over-priced high-tech services.

Prescription of drugs

The Chinese health care provider has a dual role: making a diagnosis, providing treatment, and selling the drugs they prescribe. Most hospitals own and operate pharmacies. Sale of drugs is the most important way for hospitals to generate profit. National data show that 60% of hospitals' revenue was generated by selling drugs (Dai 1993). It is also reported that about 30–40% of drug consumption represented inappropriate utilization, and the waste was more than 30 billion Chinese yuan per year (Xinhuashe 1996). It has been estimated that the drug profit could make up at least 50% of the cost-fee gap or 25% of a hospital's total costs (Chen 1993).

Organizational and management issues

Chinese public hospitals employ doctors who usually work in rotation to provide outpatient and inpatient services within the hospitals. All of the hospital-based doctors are salaried staff. In order to achieve the financial goal of the hospitals and motivate doctors to provide more services and prescribe more drugs, doctors have been paid a bonus since the 1980s. The most popular bonus system in the 1990s is the so-called Revenue-Related Bonus, which links a doctor's bonus to the revenue generated by this doctor through his/her provision of services and prescription of drugs. The most common practice among hospitals is that each department of a hospital is given a revenue target, and the department can use the residual income to pay bonuses for the department staff. The total bonus of the department is then distributed among members of the department using a formula combining seniority and work performance. Another practice is that the bonus payment is directly linked to the individual doctor's prescriptions, where the prescribing physicians can retain a specified percentage of the drugs sold to their patients. For profitable high-tech services, the hospital usually gives doctors a per-prescription bonus. For example, most county hospitals in Shandong provide a 10 yuan bonus to the doctor for each CT test ordered.

These managerial devices have proven to be very effective in hospitals' pursuit of financial goals. According to a survey of

3000 general hospitals conducted in 1994 (Mao 1995), the gross revenue of hospitals practicing the Revenue-Related Bonus System increased by 27.2%, despite the number of visits falling by 3.8% and the bed occupancy rate by 4.3% in 1994 compared to the previous year. In other words, the cost per case increased by 30%. National data on the consumption of drugs (see Table 4) show that the per capita consumption of drugs increased from 5.3 to 7.35 yuan from 1979 to 1985, an increase of only 2 yuan. This rate was significantly increased with the inception of hospital financing reform and introduction of the bonus payment system. The per capita drug consumption almost tripled from 1985 to 1992, increasing from 7.35 to 20.8 yuan. While not the only driving force, 'induced demand' out of the profit-making motive on the part of health care providers appears to be an important factor affecting medical cost inflation in China.

The profit earned from drug selling, over-charging and excessive use of high-tech equipment functioned as a cross-subsidy to the under-priced services and enabled the hospitals to survive and thrive. A question may arise from a welfare economics point of view: what is the impact on consumers? According to some simulation studies, hospitals have to over-sell a high volume of profitable services to generate small profit (World Bank 1997). If the hospitals provide unnecessary drugs and services, the hospitals' cost recovery will result in higher and unnecessary cost to consumers. For example, drugs have an allowed mark-up of 15%. In order to generate 100 yuan of revenues above cost, a hospital has to increase its drug prescriptions by 666 yuan. Therefore, the cross-subsidization in fact shifts the cost from the government (in the form of a subsidy) to the patients. Under the current situation of distorted fees consumers are worse off than if the fees were regulated at their cost levels.

Discussion

Problems of price distortion

As in many other developing countries, China's hospital sector reforms have been characterized by the decentralization of administrative and managerial responsibilities, and an increasing emphasis on cost recovery through user fees. While the Chinese government reduced the budget to public hospitals, the fee levels were still highly regulated at a lower-than-cost level, a well-intentioned effort to protect patients from excessive medical costs. However, this pricing policy has proven to be ineffective. Despite a decrease in the overall hospital admission and outpatient visits in recent years, hospital

Table 4. The national consumption of drugs from 1979 to 1992

Years	Population (10 000)	Total consumption (10 000 yuan)	Consumption/capita (yuan)
1979	97 542	517 448	5.30
1180	98 256	534 931	5.44
1981	99 522	561 090	5.64
1982	101 514	624 017	6.15
1983	102 495	693 501	6.77
1984	103 475	737 493	7.13
1985	104 639	769 588	7.35
1986	106 008	918 383	8.66
1987	108 000	1 118 837	10.35
1988	109 674	1 437 104	13.10
1989	111 191	1 580 797	14.22
1990	114 333	1 790 835	15.66
1991	115 823	2 078 991	17.95
1992	117 171	2 439 755	20.82

Sources: Chen (1995); Guo (1996).

costs have been increasing very rapidly in China. This is due to several factors.

- (1) There are law-enforcement problems. Even though most of the hospital services are priced below the actual costs, we found that more than 50% of the service items are actually charged by the hospitals at fee levels higher than the regulated prices. The health authorities and the State Pricing Commission officials have not cooperated well in this regard.
- (2) Low regulated prices for labour inputs lead to not insignificant under-the-table payment (the so-called 'red envelop money') to the health care providers, thus imposing additional financial burden on many low-income patients. This problem is prevalent in many transitional economies (Chawla and Berman 1998).
- (3) Distorted medical fees result in distorted service provision and low efficiency of resource use. Since prices of new medical technology and drugs are priced high above the costs, hospitals have stronger incentives to over-provide those services. Indeed, there is evidence to indicate a serious problem of induced demand for these profitable services, which are often unnecessary, if not outright harmful to patient health.

Strategies to reform hospital financing in China

China's experiences clearly indicate the need for developing a coordinated policy, if efficiency and equity goals are to be promoted in hospital financing reforms. Essential elements of such a policy should include the following strategies.

First, if the government is not prepared to provide full funding to public hospitals, it should allow hospitals to charge fees that cover the gap between the costs and the government subsidies. In particular, the price of medical professionals' labour, which has been traditionally under-valued, should be readjusted

upward in light of the importance of and willingness to pay for better doctor-patient interactions. On the other hand, the relatively high price of high-tech medicine, which has led to a diagnostic-equipment race involving most of China's hospitals and many health centres, should be adjusted downward. This will not totally solve the problem of induced demand, but it certainly will help reduce the incentive to over-provide unnecessary and harmful services to generate targeted income.

Secondly, to combat overuse and misuse of pharmaceuticals, the government could consider several measures: take the profit out of prescribing (e.g. establish independent pharmacies, change the fee-for-service system to a case-based payment); change insurance benefit packages to incorporate high copayment levels for outpatient drug prescriptions to reduce excess demand; educate providers and consumers about formularies and essential drugs lists; monitor prescribing patterns and provide feedback to physicians.

Thirdly, reform the fee-for-service payment systems. While certain distortions could be corrected by restructuring hospital prices, the incentive for increasing service volume, and thus revenue, is always there as long as fee-for-service is the dominant payment method. Having examined determinants of health expenditure in 19 OECD countries, Gerdtham et al. (1992) find that fee-for-service payment is associated with roughly 11% higher health care expenditure. A recent report by the World Bank recommends that China move from fee-for-service to some forms of prospective payment or case-based hospital payment systems (World Bank 1997). Some experimental schemes to reform hospital payment systems have already taken place in China, and systematic assessment of their impact should shed light on the viability of alternative pricing and payment strategies to control costs and improve efficiency.

Fourthly, public subsidies should be better targeted. In light

of the failure of price regulation in protecting vulnerable patients, other steps need to be taken to improve the urban poor's access to hospital services. The government could consider redirecting existing hospital subsidies (4.5 billion yuan) that are currently not targeted to the poor. These subsidies could focus on public facilities in poor areas of the cities, on programmes that particularly benefit the poor such as maternal and child health programmes, or on individual poor households (e.g. in the form of hospital vouchers entitling the holder to free inpatient services in participating hospitals), as has been practised by some charitable organizations in cities like Shanghai.

Last but not least, an effective monitoring and control system needs to be established. Currently, control of the health sector in China relies on a self-policing system, where health care providers, especially tertiary hospitals have a monopoly power, and the rights of the patients are very limited. Malpractice suites are very rare, and there is a lack of well-organized purchasers negotiating with medical organizations on behalf of the patients. As our empirical studies show, most of the hospitals violated pricing regulations by overcharging patients, without being held accountable for their actions. Therefore, it is of vital importance to develop adequate mechanisms for effective law-enforcement. Without this precondition, no matter how good a reform policy might be, it would remain an empty promise.

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Biographies

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